SOONERCARE - TERMS AND CONDITIONS

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I. PREFACE

HEALTH CARE FINANCING ADMINISTRATION
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00048/6

TITLE: SoonerCare

AWARDEE: Oklahoma Health Care Authority

The following are terms and conditions for the award of the SoonerCare waiver request. The terms and conditions have been broken down into three broad subject areas (Operational Conditions for Approval, Legislation, and Program Design/ Operational Plan). In addition, specific requirements are attached entitled Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration (Attachment A), General Administrative Requirements (Attachment B), General Reporting Requirements (Attachment C), Monitoring of Budget Neutrality (Attachment D), Access Standards (Attachment E), Outline for the Operational Protocol (Attachment F), and Recommended Minimum Data Set (Attachment G). Throughout this document, "managed care organization" (MCO) refers to fully capitated health plans, "partially capitated plan" (PCP) refers to arrangements for Primary Care 11 and Outpatient Networks, and "plan" refers to MCOs and PCPs.

11. GENERAL CONDITIONS

1. All special terms and conditions prefaced with an asterisk (*) contain requirements that must be approved by the Health Care Financing Administration (HCFA) prior to marketing, enrollment, or implementation of any aspect of this demonstration not previously implemented under the State's 1915(b) waiver (which will be fully subsumed within the approved 1115 program). No Federal Financial Participation (FFP) will be provided for any marketing, enrollment or implementation until HCFA has approved these requirements. FFP will be available for project development and implementation, and for compliance with terms and conditions, the readiness review, etc. Unless otherwise specified where the State is required to obtain HCFA approval of a submission, HCFA will respond to the submission in writing within 30 days of receipt of the submission. HCFA and the State will make every effort to ensure that each submission is approved within 60 days from the date of HCFA's receipt of the original submission.

"2. Within 60 days of award, the State will submit a pre-implementation workplan for approval by the HCFA project officer. The workplan will specify timeframes for major tasks and related subtasks for managed care expansion.

"3. The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and HCFA during the course of the demonstration negotiation and approval process. The document will focus on the implementation of managed care in rural areas, with an attachment describing existing managed care arrangements in urban areas for currently enrolled beneficiaries that will not be subject to HCFA review and approval under this protocol. All sections of the protocol, except the section addressing health services to Native American populations (Term IV.G), must be submitted to the HCFA project officer no later than 90 days prior to the implementation date of the 1115 program (implementation defined as the first day of enrollment of eligibles in the rural component of the Soonercare 1115 program.) The section addressing health services to Native American populations must be submitted no later than 60 days prior to implementation. HCFA will respond within 30 days of receipt of the sections of the protocol regarding any issues or areas it believes require clarification. HCFA and the State will make every effort to ensure that the entire protocol is approved within 60 days from the date of its original submission. During the demonstration, subsequent changes to the protocol which are the result of changes in State policy or operating procedures should be submitted to the HCFA project officer no later than 90 days before the date of implementation of the change(s). The Special Terms and Conditions and Attachments include requirements which should be included in the protocol. Attachment F is an outline of areas that should be included in the protocol. Where not specified in the protocol, the State's original waiver proposal, as modified in written responses to HCFA questions, shall govern.

4. a. The State will submit to HCFA a phase-out plan for the Soonercare demonstration six months prior to initiating normal phase-out activities and, if desired by

the State, an extension plan on a timely basis to prevent disenrollment of Soonercare members if the waiver is extended by HCFA. Nothing herein shall be construed as preventing the State fiom submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan is subject to HCFA review and approval.

5. The State will comply with:

a. Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration (Attachment A)
b. General Administrative Requirements (Attachment B)
C. General Reporting Requirements (Attachment C)
d. Monitoring of Budget Neutrality (Attachment D)
e. Access Standards (Attachment E)
f. Outline for Operational Protocol (Attachment F)

A. Subsumed 1915(b) Waiver

Upon commencement of the 1115 demonstration, the State's 1915(b) waiver will be subsumed into the 1115 program and will no longer exist as a separate waiver program.

B. Capitation Rates

1. The State will submit to HCFA for review and approval all capitation rates, and the fee-for-service upper payment limits from which they are derived, for the plans throughout the duration of the demonstration. Also, the State will submit the methodology for determining the fee-for-service upper payment limits for services. Capitation rates developed for urban plans previously participating in the 1915(b) waiver will be submitted but will not be subject to further HCFA review and approval. However, upon contract renewal, all capitation rates for urban plans will be subject to HCFA review and approval.

C. Rural Partners

For purposes of this document, "rural" is defined to be those areas of the State outside the Oklahoma City, Tulsa, and Lawton metropolitan areas, as described in Chapters III and IV of the 1115(a) waiver application.

1. Urban MCOs will be eligible to operate under the full set of waivers accorded to the 1115 demonstration project (as described in the waiver award letter issued by HCFA), upon certification by the State, in consultation with HCFA, as a "Rural Partner." To qualify for "Rural Partner" status, an urban MCO must:

a. Contract with the State to enroll and serve Soonercare beneficiaries in one or more rural service areas as a fully capitated MCO or partially capitated Outpatient Network, with rural capacity equal to at least 500 Soonercare-eligible individuals or 10 percent of the plan's metropolitan capacity, whichever is greater; or

b. Serve as a contract manager for a fully capitated MCO or partially capitated Outpatient Network (performing plan administrative functions such as claims processing and encounter reporting), subject to the capacity test described above; or

c. Provide the tertiary/specialist referral component for one or more rural MCOs/Outpatient Networks, subject to the capacity test described above; or

d. Establish and operate a telemedicine consultation/referral system that includes at least 25 Oklahoma hospitals located in rural service areas (as defined by the State); or

e. Propose an alternative method to the State for significantly increasing access to managed health care among rural Soonercare beneficiaries/providers, subject to State and

HCFA approval.

2. Any certification by the State that a health plan has met one of the "Rural Partner" conditions will be subject to approval by HCFA. HCFA would have 30 calendar days in which to approve or disapprove this certification, or ask one set of formal questions. In the latter case, HCFA would have 30 calendar days upon receipt of the State's response to HCFA's questions in which to approve or disapprove this certification. If no action is taken within 30 days, the certification would be considered approved.

3. An urban MCO which is certified as a "Rural Partner," as described above, will be eligible to operate under the full set of 1115 waivers no later than the first day of the third month following such certification.

D. Plan Contracting

(Terms 1, 2, and 3 will only apply to contracts executed after the start date of the demonstration).

1. The State will use a Request for Proposal (RFP) process to select contracting MCOs in urban and rural areas. This process will be open to all plans/networks that meet Soonercare 1115 demonstration participation standards, including minority-owned plans. The process for selecting contracting MCOs shall apply only to fully-capitated comprehensive health plans.

*2. Before issuing the solicitation for MCOs, the State shall submit the Request For Proposal (RFP) for review by HCFA. HCFA will have 30 days to provide comments to the State.

3. a. Model contracts between the State and plans must be approved by HCFA prior to the start date of the delivery of services.

b. The State will provide HCFA with 30 days to review and approve the model contract prior to its use. No FFP will be available for contracts using a model which has not been approved by HCFA in advance of the effective dates of such contracts.

c. HCFA reserves the right to review and approve individual subcontracts with plans in accordance with the same requirements as those imposed by these Special Terms and Conditions on plans. Copies of subcontracts or individual provider agreements with plans shall be provided to HCFA upon request.

d. The State shall establish a process by which it receives, reviews, and approves all marketing materials prior to their use by MCOs and

provide HCFA with an annually updated listing of all providers (primary and specialty) participating in the demonstration.

e. In the protocol, the State will provide assurances to HCFA that managed care is being implemented only in areas that have sufficient provider capacity, as defined by the State's methodology.

f. In the protocol, the State shall describe how homeless populations will access health care services under the demonstration. The protocol will include a description of how providers of care to this population will be incorporated into the managed care model and reimbursed for their services to this population.

*5. The State must meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B, for contracting with plans prior to the start date of the demonstration. Such requirements include disclosure of ownership and completion of the standard HCFA disclosure form.

E. Streamlined Eligibility

Oklahoma shall submit to HCFA a plan describing how the State will implement appropriate and effective systems to ensure "real-time" enrollment. Upon HCFA review and approval of the plan, the waiver of retroactive eligibility (section 1902(a)(34)) will take effect.

F. Family Planning

1. All urban MCOs except those designated as "Rural Partners" for their rural area contracts (as described above) must permit enrollees direct access to Title X clinics. Rural Plans are not required to contract with Title X providers.

*2. In the protocol, the State should provide HCFA with a description of available family planning services and assurances that access to these services by minors is not restricted by the Soonercare 1115 demonstration.

3. The State will provide HCFA with any amendments to the Title X provider agreements which occur as a result of the demonstration.

G. Health Services to Native American Populations

In the protocol, the State shall submit to HCFA a plan, developed in consultation with the Indian Health Programs, consisting of Indian Health Service (IHS) and tribally-operated programs, for patient management and coordination of services for Indian Medicaid eligibles referred to private providers by Indian Health Programs through the IHS Contract Health Services (CHS) program. The plan shall include mechanisms and procedures for the Indian Health Programs and PCPs/MCOs to follow to ensure Medicaid coverage and payment of services received by IHS/CHS Medicaid eligibles. The plan shall also include a monitoring protocol to assess the impact of Soonercare on health service delivery to Native Americans. The State shall submit on an annual basis program enrollment data for this population, and shall make this data available to the Indian Health Programs upon request.

H. EPSDT Services

In the protocol, the State shall submit to HCFA its plan for ensuring that the full range of EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services, including outreach and preventive care, are provided by plans participating in the Soonercare 1115 demonstration as well as assurances that access to these services is not restricted by the Soonercare 1115 demonstration.

I. Federally Qualified Health Centers (FQHCs)

*1. a. The State shall as a general rule require MCOs and Outpatient Networks to contract with FQHCs in their service area. However, if the State can demonstrate to HCFA that the plans have adequate capacity and will provide an appropriate range of services for vulnerable populations without contracting with an FQHC in its service area, the MCO/Outpatient Network can be relieved of this requirement.

b. For any MCO/Outpatient Network that requests an exemption from the requirement that it contract with FQHCs, the State shall submit to HCFA a report with the following information at least 60 days prior to submission of the final managed care contract for HCFA approval:

1) The FQHCs in the MCO/Outpatient Network's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.

2) An analysis that the MCO/Outpatient Network has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers signed with the MCO/Outpatient Network, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The MCO/Outpatient Network must inform the State if any of this information or data changes over the course of the demonstration.

3) An analysis that the MCO/Outpatient Network will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State Medicaid plan), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients, to the extent these services are currently available through FQHCs in the service area.

c. The MCO/Outpatient Network will pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. A description of the payment methodology shall be provided by the State. If during the demonstration, the MCO/Outpatient Network changes its payment methodology to an FQHC, the changes must be submitted by the State to HCFA for review and approval.

J. Encounter Data Requirements

*1. a. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The recommended minimum data set is attached. The State must perform periodic reviews, including validation studies, in order to ensure compliance, and shall have provisions in its contract with the Plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. As part of the protocol, the State shall submit the proposed minimum data set and a workplan showing how collection of plan encounter data will be implemented and monitored in urban and rural areas, what resources will be assigned

to this effort, and how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis. If the State fails to provide reasonably accurate and complete encounter data for any MCO or PCP, it will be responsible for providing to the designated HCFA evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

b. The State, in collaboration with MCOs, PCPs, and other appropriate parties, will develop a detailed plan, as part of the protocol, for using encounter data to pursue health care quality improvement. At a minimum, the plan shall include: how the baseline for comparison will be developed; what indicators of quality will be used to determine if the desired outcomes are achieved; where the data will be stored; how data will be validated and how monitoring will occur; and what penalties will be incurred if information is not provided.

c. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas:

- childhood immunizations;
- prenatal care and birth outcomes;
- pediatric asthma; and
- one additional clinical condition to be determined by the State based upon the population(s) served.

d. The State shall conduct annual validity studies to determine the completeness and accuracy of the encounter data collected. As part of the protocol, the State shall submit a plan for HCFA approval describing how it will validate the completeness and accuracy of the encounter data.

K. Quality Assurance Requirements

*1. In the protocol, the State shall provide its overall quality assurance monitoring plan for all plans. The State shall develop internal and external audits to monitor the performance of the plans under Soonercare 1115 demonstration. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan. In the protocol, the State shall provide detailed criteria for monitoring the financial performance and quality assurance of

each plan. The plan must include contingencies if an MCO network is terminated or plans become insolvent. The State shall submit to the Office of Research and Demonstrations (ORD) and the HCFA Regional Office copies of all financial audits of participating plans and quality assessment reviews of these plans, including findings from all licensure inspections.

2. a. Within 12 months of implementation of the demonstration, the State shall conduct a survey of all beneficiaries. The survey, which shall be described in the protocol, will measure satisfaction and include measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to special providers; and the number and causes of disenrollment; and coordination with other health programs. Results of the survey must be provided to HCFA by the fifteenth month of project implementation. Thereafter, the State shall conduct beneficiary surveys during each year of the demonstration as part of its quality improvement and performance monitoring process. such survey shall be designed to produce statistically valid results.

b. The State shall establish a quality improvement process for bringing plans which do not meet the State minimum standard for beneficiary satisfaction up to an acceptable level.

3. The State shall collect and review quarterly reports on grievances received by each MCO and PCP which describe the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled.

4. Guidelines for State Monitoring of Plans

a. The State will require, by contract, that plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.34.

b. The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), plans' adherence to these standards, through the following mechanisms: review of each plan's written QAP; review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes; and on-site monitoring of the implementation of the QAP

Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration

Those items prefaced with an asterisk (*) contain requirements that must be approved by the HCFA prior to marketing, enrollment, or implementation.

a. The State will report net expenditures in the same manner as is done under the current Medicaid program. The State shall provide quarterly expenditure reports using the form HCFA-64 to separately report expenditures for those receiving services under the Medicaid program and those participating in Soonercare under section 1115 authority. HCFA will provide Federal Financial Participation (FFP) only for allowable Soonercare expenditures that do not exceed the predefined limits as specified in Attachment D.

b. Oklahoma will report SoonerCare expenditures through the MBES, following routine HCFA-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. In this regard, Soonercare expenditures will be differentiated from other Medicaid expenditures by identifying on forms HCFA-64.9 and/or 64.9p the demonstration project number assigned by HCFA. Because expenditures are reported on the HCFA-64 by date of payment, Oklahoma must also submit along with each HCFA-64 quarterly report a supplemental schedule that details services and reported waiver expenditures according to the waiver year in which the services were provided. The procedure related to under this reporting process must be approved by HCFA as part of the protocol referenced in Section 113 of these Special Terms and Conditions.

c. All claims for Soonercare services provided during the demonstration period (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. During the period following the conclusion or termination of the demonstration, the State must continue to separately identify Soonercare waiver expenditures using the procedures addressed above.

d. In addition to the form HCFA-64, the State shall provide to HCFA on an quarterly basis the number of eligible member/months for each enrollee group listed in Attachment D. This information should

be provided to HCFA 30 days after the end of the quarter.

2. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Oklahoma Medicaid and Soonercare expenditures on the quarterly form HCFA-37. The State must provide supplemental schedules that clearly distinguish between waiver expenditure estimates (by major component) and non-waiver Medicaid expenditure estimates. HCFA will make Federal funds available each quarter based upon the State's estimates, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. HCFA will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

3. HCFA will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:

a. Administrative costs associated with the administration of Soonercare.

b. Net expenditures and prior period adjustments of the Medicaid program which are paid in accordance with the approved State plan. HCFA will provide FFP for medical assistance payments with dates of service prior to and during the operation of the section 1115 waiver.

c. The State will certify State/local monies used as matching funds for Soonercare purposes and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

4. Guidelines for Financial Monitoring of Participating Providers

a. The State shall provide to HCFA, upon request, copies of all financial statements filed by insurers and MCOs and Outpatient Networks with the Oklahoma Department of Insurance.

b. The State shall provide to HCFA, upon request, copies of any Department of Insurance documents related to their monitoring of the financial stability of insurers and MCOs and Outpatient Networks.

c. The State shall provide to HCFA, upon request, copies of all

audits conducted by the State under the Federal Single Audit Act.

General Administrative Requirements

Those items prefaced with an asterisk (*) contain requirements that must be approved by the Health Care Financing Administration (HCFA) prior to marketing, enrollment, or implementation.

1. Oklahoma will request modifications to the demonstration by submitting revisions to the protocol (special term and condition #3) for HCFA approval. These modifications will include technical changes in policy and procedures. The State shall not submit amendments to the approved State plan relating to the new eligibles.

2. Substantive changes to the demonstration design (i.e., family planning expansion, and the inclusion of institutionalized individuals within the waiver population) will require submission of a formal amendment to the proposal and advance HCFA approval. The State will work with HCFA in amending the waiver application in the later stages of the demonstration program.

3. By April 1 of each year, the State will submit Form HCFA-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. Copies should be submitted simultaneously to HCFA's Dallas Regional Office and to the HCFA Central Office address contained in section 2700.4 of the State Medicaid Manual. All data reported must be supported by documentation consistent with the general requirements of these terms and conditions.

4. All contracts and subcontracts for services related to the Oklahoma Soonercare 1115 demonstration must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and (2) inspect and audit any financial records of such contractor/subcontractors. This includes contracts with MCOs, PCPs, and Third Party Administrators (TPAs).

Attachment C

General Reporting Requirements

Those items prefaced with an asterisk (*) contain requirements that must be approved by the Health Care Financing Administration (HCFA) prior to marketing, enrollment, or implementation.

1. a. Through the six months after implementation, the State will provide monthly progress reports through a series of monthly conference calls with the HCFA project officer, .and will develop a detailed agenda prior to each call. Subsequently, the State will submit quarterly progress reports (including grievances), which are due *60* days after the end of each quarter.

   b. The reports should include a discussion of events occurring during the quarter that affect health care delivery, enrollment and outreach, quality of care (including statistics on complaints and grievances), access, plan financial performance, the benefit package, and other operational issues. The reports should include a separate discussion of State efforts related to the collection and verification of encounter data and provide summary utilization statistics (beginning in the Third Quarter). The reports should also include proposals for addressing any problems identified in each report.

2. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from ORD, a final annual report will be submitted.

3. At the end of the demonstration, a draft final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

4. The State shall submit a continuation application by October 1 of each year (beginning in 1996).

Attachment D

Monitoring Budget Neutrality for the Oklahoma Soonercare Program

The following describes the method by which budget neutrality will be assured under the Oklahoma Soonercare Demonstration. Oklahoma will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, Oklahoma will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all current eligibles, HCFA will not place Oklahoma at risk for changing economic conditions. However, by placing Oklahoma at risk for the per capita costs of current eligibles, HCFA assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year, on a Federal Fiscal Year (FFY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire waiver period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 8-year period in which budget neutrality will be enforced January 1,1996 through December 31,2003) for the types of Medicaid expenditures described below. For each FFY, the Federal share will be calculated using the FMAP rate for that year.

Each yearly budget estimate will be the sum of separate cost projections for each of four Medicaid enrollment groups (MEG). These are groups of recipients who are currently participating in the Oklahoma's Medicaid program, and would participate in the Soonercare program. The four enrollee groups are: (1) Aid to Families with Dependent Children (AFDC) recipients in urban areas (AFDC-Urban); (2) AFDC recipients in rural areas (AFDC-Rural); (3) Aged, Blind, and Disabled (ABD) Medicaid recipients (regardless of SSI eligibility) in urban areas (ABD-Urban); and (4) ABD Medicaid recipients (regardless of SSI eligibility) in rural areas (ABD-Rural). For this purpose, urban areas are those as defined in the State's December, 1994, waiver application. The yearly cost projection for each MEG will be the product of the projected per capita cost for that MEG, times the actual number of recipient member/months reported to HCFA by the State under the terms of Attachment A.

Should the State fail to include the appropriate Form HCFA-64.9 and Form HCFA-64.9p waiver reports separately identifying all SoonerCare demonstration expenditures with its Quarterly Expenditure Report (Form HCFA-64) for the period ended March 31,2000, as required by Special Term and Condition (ST&C) #1.b of Attachment A, the State will be out of compliance of this Special Term and Condition. Until the State is in compliance with ST&C #1.b of Attachment A, HCFA will not consider for review any amendment requests from the State, pursuant to ST&C #1 and 2 of Attachment B. The granting of the waivers needed for this demonstration requires the State's compliance with all the special terms and conditions.

Also, should HCFA determine that Soonercare was not budget neutral during the initial five-year operational period, HCFA may require the State to return the excess FFP to the extent Soonercare expenditures exceed the budget neutrality provisions, during the sixth or any subsequent year. The State, whenever it determines that the demonstration is not budget neutral or is informed by HCFA that the demonstration is not budget neutral, shall immediately collaborate with HCFA on corrective actions, which shall include submitting a corrective action plan to HCFA within 21 days of the date the State has been informed of the problem. While HCFA will aggressively pursue corrective actions with the State, HCFA would work with the State to set reasonable goals in years 6, 7, and 8 that would ensure that the State is in compliance by year 8, and to reach consensus with the State on the amount the State is over the budget for the initial five-year operational period. As part of the corrective action plan the State will commit to repaying the over budget amount to HCFA should the State become noncompliant with the corrective action plan at any time. Repayment by the State would begin no earlier than year 6.

Budget neutrality will be determined on an eight year basis rather than on an annual basis. Any savings from budget neutrality may only be applied to an eligibility expansion or to offset demonstration costs in excess of the budget neutrality caps during this period. The State must submit for HCFA approval a waiver amendment requesting the expansion. in its amendment, the State must demonstrate that the expansion is sustainable, even when the accrued savings from the initial five-year waiver period are exhausted.

Projecting Per Member/Per Month (PMPM) Costs

Projected PMPM cost for each category will be determined by using a pre-determined set of trend factors to convert base year PMPM costs into current year PMPM costs for each year of the demonstration.

Base year
The base year PMPM costs conform to the following requirements:

- They must reflect expenditures related to services performed during State fiscal year (SFY) 1995 (i.e., expenditures should be totaled on a date of service basis) for all enrollees in the groups listed above.

- They must include expenditures for all services for which prepaid plans will be responsible under the demonstration. In particular, they must include expenditures for all services meeting the above description which plan members are entitled to receive on a fee-for-service basis from non-plan providers, including but not limited to services performed at Indian Health Service facilities, services performed in a school based setting that are not required under the student's Individual Education Plan, and family planning services.

- The recipient totals used must include all recipient member/months that would have participated in the SoonerCare demonstration had that program been in place in SFY 95.

Trend Rates

The following are the specific trend rates that will be used to project per member/per month (PMPM) costs for each year of the demonstration. Each figure below is percentage change in PMPM cost fiom the prior to the current Federal fiscal year.

AFDC	ABD
6.51%	5.86%

Using the trend rates to produce waiver year PMPM cost estimates

Because the beginning and end of the demonstration do not coincide with the Federal fiscal year, the following methodology will be used to produce waiver year (WY) estimates of PMPM cost. The first waiver year (WY 96) will begin January 1, 1996 and end December 31, 1996. Since WY 96 is one and one-half years advanced in time from the base year (SFY **95),** one and one half years of growth must be applied to convert SFY 95 costs into their WY 96 equivalents. These growth rates will be:

AFDC	ABD
9.92%	8.92%

To produce PMPM for WY 97 and beyond, the first set of growth rates will be used.

Removing 1915(b) managed care savings fiom AFDC-Urban PMPM cost estimates

Estimated costs for AFDC-Urban recipients must be adjusted downward to remove projected savings attributable to Oklahoma's 1915(b) Medicaid managed care program, which began operations prior to the planned start of the SoonerCare demonstration. Projected PMPM costs for the AFDC-Urban population will be adjusted downward using the following formula:

(adjusted PMPM cost) = (unadjusted PMPM cost) X **[1 - SAV** X **SHARE]**

In the above formula, **SAV** is the estimated PMPM savings for those recipients in managed care; and **SHARE** is the ratio of two factors: (1) **MCMM:** projected managed care member/months that will occur during the period August 1 though December 31, 1995, and (2) **AFDCMM:** projected total AFDC-Urban member-months anticipated during SFY 96. For purposes of this calculation, the following values will be assumed for the variables listed above:
SAV = 7.1%
MCMM = 105,189
AFDCMM = 1,160,381
SHARE = **MCMM** divided by **AFDCMM** = 9.07%

Sample Calculation

Suppose the base year per capita cost for the AFDC-Urban MEG is $134.13. Using the growth rate above, unadjusted AFDC-Urban PMPM cost for WY 96 would be $147.44. Applying the adjustment formula to remove 1915(b) savings gives the following: $147.44 times [1 - (.071) X (.0907)] = $146.49, which represents adjusted AFDC-Urban PMPM cost. The adjusted cost is then multiplied by actual total AFDC-Urban member/months to produce a projected total expenditure for AFDC-Urban recipients in WY 96. 'The same procedure is repeated for the other MEGs (except no adjustment factor is applied for non-AFDC-Urban) and for the remaining years of the demonstration. The Federal share of the resulting total represents that maximum amount of FFP that the State may receive for the affected recipient populations over the course of the demonstration.

How the limit will be applied

The limit calculated above will apply to actual expenditures, as reported by the State under Attachment A, Special Term and Condition #1(b). If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to HCFA. No new limit is placed on FFP that the State may claim on expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 8-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

HCFA shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later that six months after the end of each waiver year, the State will calculate annual expenditure targets for the completed year. The annual component targets will be summed to calculate a target annual spending limit. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these cumulative targets they shall submit a corrective action plan to HCFA for approval. The State will subsequently implement the approved program.

- Year 1 target spending limit	+8 percent
- Years 1 to 2 combined target spending limit	+6 percent
- Years 1 to 3 combined target spending limit	+4 percent
- Years 1 to 4 combined target spending limit	+2 percent
- Years 1 to 5 and beyond - the combined target spending limit	+0 percent

Attachment E

Access Standards

Contractors shall provide available, accessible, and adequate numbers of institutional facilities,

service locations, service sites, professional, allied and paramedical personnel for the provision of all covered services on an emergency basis, 24-hour-a-day, 7-day-a-week basis. At a minimum, unless Oklahoma can demonstrate otherwise, this shall include:

- Primary Care Delivery Site:

  (a) Distance/Time: No more than 30 miles or 30 minutes for all enrollees in an urban service area, and no more than **45** miles or 45 minutes for all enrollees in a rural service area.

  (b) Patient Load: A SoonerCare 1115 demonstration patient/primary care physician ratio to be determined by Oklahoma and approved by the HCFA project officer 30 days prior to implementation of the program.

  (c) Appointment/Waiting Times: Usual and customary practice not to exceed 30 days from date of a patient's request for routine and preventive office visits and 48 hours for urgent care.

  (d) Documentation/Tracking requirements:

  + Documentation - **MCOs** and Outpatient Networks must have a system in place to document appointment scheduling times. Oklahoma must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the required beneficiary survey.

  + Tracking - All plans must have a system in place to document the exchange of client information with the primary care provider if a school-based health center, not serving as the primary care provider, provides health care.

- Specialty Care and Emergency Care: Referral appointments to specialists, except for specialists providing mental health and substance abuse services, (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts.

- Hospitals: Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater and for mental health and physical rehabilitative services where access is not to exceed 60 minutes. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to Oklahoma on the basis of community standards.

- General Dental Services:

  (a) Transport time will be the usual and customary, not to exceed one hour, except in rural areas where community standards and documentation will apply.

(b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care.

- General Optometry Services:

(a) Transport time will be the usual and customary, not to exceed one hour, except in rural areas where community standards and documentation shall apply.

(b) Appointment/Waiting Times: Usual and customary not to exceed 30 days for regular appointments and 48 hours for urgent care.

- Pharmacy Services:

(a) Transport time will be the usual and customary, not to exceed one hour, except in rural areas where community access standards and documentation will apply.

- Lab and X-Ray Services:

(a) Transport time will be the usual and customary, not to exceed one hour, except in rural areas where community access standards and documentation will apply.

(b) Appointment/Waiting Times: Usual and customary not to exceed 30 days €or regular appointments and 48 hours for urgent care.

- All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary" - access that is equal to or greater than the currently existing practice in the fee-for-service system.

Attachment F

Outline for Operational Protocol

Oklahoma will be responsible for developing a detailed protocol describing the Oklahoma Soonercare 1115 demonstration. The protocol is a stand alone document that reflects the operating policies and administrative guidelines of the demonstration. The State shall assure and monitor compliance with the protocol. Areas that should be addressed in the document include:

1. organizational and structural configuration of the demonstration arrangements, in particular the transition of urban plans to the "Rural Partner" status, and the inclusion of the ABD population.

2. organization of managed care networks, and procedures for determining adequate managed care provider capacity by county.

3. payment mechanism, including (a) the reimbursement of IHS, family planning, and school-based clinics on a fee-for-service basis and the resulting adjustments to the plans' capitation rates, and (b) the reimbursement of services provided between the date of Soonercare eligibility and the date of enrollment in a health plan.

4. benefit package, including provision and monitoring of non-emergency transportation services

5. marketing and outreach strategy (i.e., (a) State-initiated marketing and recipient education activities, including the method for educating urban beneficiaries about the different characteristics of "Rural Partner" plans, and (b) oversight of plan-initiated marketing activities.)

6. enrollment process

7. quality assurance and utilization review system

8. administrative and management system

9. encounter data (in primary care 11, outpatient networks, and MCOs).

10. federally qualified health centers and rural health centers

11. IHS facilities and tribally owned facilities

12. family planning services

13. financial reporting

14. State contingency plans in the event of MCO contract termination or insolvency

15. recipient complaints, grievance and appeal process

Recomme N

ELEMENTS	PLACE OF SERVICE				
	AMBL	HOSP	LTC	DRUGS	DENTAL
Recipient ID	X	X	X	X	X
Recipient Name	X	X	X	X	X
Recipient Date of Birth	X	X	X	X	X
Insured's ID	X	X	X	X	X
Facility ID	X	X	-	-	-
Plan ID	X	X	X	X	X
Physician/Provider ID	X	-	X	X	X
Specialty Code	X	-	-	-	-
Provider Location Code	X	X	X	X	X
Place of Service	X	-	-	-	X
Principal Diagnosis Code	X	X	-	-	
Other Diagnosis Code	X	X	-	-	-
Procedure Code	X	X	-	-	-
EPSDT Indicator	X	-	-	-	X
Date of Service	X	X	-	X	X
Units of Service	X	-	-	-	X
Attending/Referring Phys ID	-	X	-	-	-
Performing Provider ID	-	X	-	-	-
Provider Type	-	X	-	-	-
Type of Bill	-	X	-	-	-
Admission/From Date	-	X	-	-	-
Discharge/Through Date	-	X	-	-	-
Discharge Patient Dest.	-	X	-	-	-
Revenue Code	-	X	-	-	-
Begin Date	-	-	X	-	-
End Date	-	-	X	-	-
Days Since Admission	-	-	X	-	-
National Drug Code	-	-	X	X	-

STATE OF OKLAHOMA
Oklahoma Health Care Authority
***February* 5,2000**

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§1115(a) Research and Demonstration Waiver Amendments
Response to the December 18,2000 Request for Additional Information

SECTION I: Soonercare Plus Managed Care Organization Delivery Payments

1. *Please recalculate the delivery payments In Exhibit IV on page 10. The calculation is not consistent for the contract years. One of the delivery payment calculations appears to include the supplemental resident delivery payment while the others appear not to include the additional payment. The supplemental delivery payments should be reported without any other supplemental payments included If this was made in error, please correct and send corrected page.*

   RESPONSE: The reason for this discrepancy is that resident delivery payments begin in Year V (July 1, 1999 – June 30, 2000). These payments are not included in previous years as noted on page 9 in the original waiver amendment request. The calculations are correct but have been adjusted to exclude the resident delivery payment (see Attachment A).

SECTION 11: Native American Case Management Model Contract Payments

2. *On page 34, the State estimates savings from the amendment ranging from $2.2 million to $4.6 million annually. Please explain and provide methodology to show how these savings are generated Would there be any federal savings as well especially from Indian Health Service (IHS)-provided care that is 100% federally funded?*

3. *Please clarify on pages 35 – 36, the current payment method for PCPs/CMs and the advantages of moving to the new method The State believes that many Native American providers have not elected to contract as PCPs/CMs because the current system pays a capitated rate for both case management and some primary care services. Under the proposed system, providers would be paid a monthly case management fee but will be reimbursed for primary care services at the current (usually outpatient) rate. Is this a correct characterization? Is the State essentially proposing to move from a full capitation option to a partial capitation option?*

   RESPONSE: The initial waiver amendment request was submitted in April 2000 and as a result several changes have been suggested regarding this particular item. Therefore, the state will address this request at a later date and separate from the remaining amendment requests.

SECTION 111: EPSDT Bonus payments

4. *Please explain how the EPSDT compliance rates are established Is the State's 45% required compliance rate the usual percentage used by states?*

   RESPONSE: Historically, Oklahoma's EPSDT screening rates have been lower than desired. In 1994, the statewide EPSDT screening rate of less than 30% was reported to the Health Care Financing Administration (HCFA). During Year I (July 1, 1996 – June

30, 1997) of the ***SoonerCare Choice*** Program a financial disincentive was included as a term of the contract. The provider community responded negatively to this component and some potential providers would not contract due to risk of financial recoupment. The disincentive was replaced by an incentive or bonus payment for provider achieving a specified compliance rate and meeting contract provision.

In the PCP/CM contract for Year II (July 1, 1997 - June 30, 1998) of ***SoonerCare Choice*** program the OHCA initiated a bonus program for providers who achieved a 60% or greater EPSDT screening rate. This target screening rate remained constant throughout contract Year III (July 1, 1998 – June 30, 1999) and was increased to 70% for contract Year IV (July 1, 1999 – June 30, 2000). However, the current program requirements proved to be stringent and less than 3% of the total number of ***SoonerCare Choice*** providers were able to achieve the required compliance rate during Year II and 111.

Compliance rate requirements for Year V (July **1,** 2000, through June 30,2001) were set at 45% with annual increases during subsequent years not to exceed 10%. The initial 45% is consistent with the Statewide rate and potential annual increases with additional outreach and provider training.

Compliance rates as well as initial or periodic screen code will be determined using the method outlined in section 2700.4(E), line number 1 through 6 of the State Medicaid Director's letter dated July 1, **1999.** Refer to Attachment B included in the original waiver amendment request.

A tiered payment approach will be used for the provider panel and will be based on compliance rate achievement per age group. The OHCA will also consider an additional bonus payment for those providers that exceed 70%.

5. Please explain what measures the State will take to prevent the duplication of payments for partial and/or full EPSDT screens that are provided through School Based Services. Are adjustments made and if so, what methodology will be used to make the adjustments?

RESPONSE: This bonus payment is designed to provide more direct compensation for those providers who exceed the overall Medicaid screening rate for Oklahoma. This payment is a supplemental payment in addition to what providers are currently receiving for partial and/or full EPSDT screens.

Additionally, each year, an adjustment is made to the capitation rates for partial and/or full EPSDT screens provided through School Based Services. The amount reimbursed to schools for the preceding year is backed out of the next year's rates based upon the succeeding year's prospective member months for children between the ages of six though fourteen.

6. **Please give a brief explanation on how the State calculates the EPSDT bonus payments.**

RESPONSE: Refer to pages 115-116 of the original waiver amendment request submitted April 20, 2000, for a detailed explanation of the EPSDT bonus payment calculations.

SECTION IV: MCO Resident PCP Payments

7. *Please provide an explanation as to how the waiving of the UPL provisions of Section 1902(a)(30)(A), as implemented by 42 CFR 447.361 and 447.362 would be exercised with respect to the MCO resident PCP add-on payments.*

RESPONSE: As a result of discussions several months ago with HCFA regarding the delivery payments there appeared to be some concern that the State may exceed the UPL with regards to the cost of care specific to deliveries. By citing this particular regulation the State wanted to make HCFA aware that if we exceed the cost associated with deliveries, we have not exceed the UPL for all services provided under managed care.

SECTION V: FQHC Prospective Payment System (PPS)

8. *Please remove ALL references to the uninsured population in this section.*
9. *Please provide the methodology for the prospective payment system.*
10. *Please provide more detail as to how the State will provide ongoing verification that the FQHCs are not receiving more than 100% cost reimbursement.*
11. *Please clarify what is meant in item #2 on page 126, "Provide accessible alternatives to inappropriate emergency room care for non-emergent medical conditions." What steps is the State taking to resolve the problem?*
12. *Please clarify what is meant by 'fpool of funds" as mentioned on page 128. Also, provide methodology as to how this "pool of funds" was determined*
13. *Exhibit I on page 129 shows the unaudited base year allowable cost per encounter for each facility. Provide explanation as to why a 3% trend rate was used Show how the 3% trend rate was determined*

RESPONSE: The State is currently reviewing the option of withdrawing this waiver amendment request. The initial waiver amendment request was submitted in April 2000 and as a result of changes in federal law it may not be necessary to do a waiver amendment. The OHCA staff is currently working with the regional office project officer to determine the appropriate course of action.

SECTION VI: ABD Bridge Payments

14. *Explain how the value of the encounter claims was based in order to compare this amount to the adjusted capitation revenue received by providers. Also, provide payment rate adjustments for the past year. Please use actual or projected figures to*

calculate payments if possible. If such figures are not available, please provide a narrative explanation of how the payments would be calculated

RESPONSE: The illustration listed on page 139 of the original waiver amendment submission *"Example of* ABD *Bridge Payment Methodology "Annual and Quarterly"* consists of fictitious numbers which were placed in the exhibit to provide readers with a graphic example of how the payments would be calculated. Actual encounter data provided by participating PCP/CMs will be used to determine if a Bridge Payment will be made. The Authority evaluates PCP/CM encounter data submissions quarterly and annually to determine if an ABD bridge payment is warranted. No PCP/CM encounter data has met the ABD Bridge Payment threshold for the quarters January – March 2000; April – June 2000; July – September 2000; and October – December 2000. As a result, no adjustments have been made.

SECTION VII: Enhanced Case Management for Special Population ABDs

15. Pleaseprovide an explanation as to how the calculations on page 145 were determined especially how the average annual salary of an ENC plus 25% in benefits was determined

RESPONSE: In order to determine an ENC's average annual salary, all Health Plans were polled as to the SP/ABD caseloads of their ENCs. It was discovered that the average caseload is between 90 and 110 for SP/ABD members. Health Plans were also polled as to the salaries of their ENCs. The average salary excluding benefits is $50,000. For state government, the average cost of an employee's benefits is 28 percent of the employee's salary. Based on an average of a 100 member caseload, an ENC's salary and benefits of $62,500 ($50,00 x 125%), and an SP/ABD population of 24,000 member months (2,000 x 12), the expected cost is $1,250,000.00 ($62,500 x 20).

Calendar Year 1998 ABD Fee-for-Service population data was analyzed for those individuals residing in ***SoonerCare Plus*** service areas. This analysis showed that there were approximately 2,869 recipients qualified as SP/ABD designees. Analysis of State Fiscal Year 2000 data showed a decrease of 999 recipients. The difference between the 2,869 CY-98 recipients and the 1,870 SFY 2000 recipients was analyzed to verify that indeed those non-matching individuals no longer had ABD status in the state's Medicaid program.

The first quarter's payment for SFY 2001 will be based on the relative percentage of the 1,870 members enrolled with each health plan as of September 2000. The remaining quarter payments to the plans would be based on September's ratio, but also with the assumption that there are no more than 2,000 SP/ABD members in the ***SoonerCare Plus*** ABD program, inclusive of SP/ABD look alike members that require enhanced services due to chronic and complex medical conditions, but did not receive SP/ABD designation.

BUDGET NEUTRALITY:

16. *Please explain how the calculation used in Exhibit I on page 148 was determined It appears that some of the figures were counted twice as part of the budget neutrality assurances. It is recommended that the figures that are duplicated as an expenditure and adjustment be recorded as adjustments. Please explain the different figures used as the expenditure and adjustment for the EPSDT Bonus Payments. Please recalculate.*

RESPONSE: Expenditures on page 148 were recalculated as instructed above. Please see Attachment B for revisions.

PROTOCOL AMENDMENTS - Page 166

I. ABD Bridge Payment

Need clarification on Item #3 on page 26-g – "If the value of the encounter claims exceeds the adjusted capitation revenue, the OHCA will make an additional payment of 100% of the difference." Is the State making a bridge payment in addition to the supplemental payment?

RESPONSE: Item #3 on page 26 - g has been changed to clarify that the State is not making an "additional" bridge payment in addition to a supplemental payment (see Attachment C).

2. FQHCs

Please explain on page 26-i, what is meant by "...no access to mainstream providers? Please explain on page 26 - j, what is meant by "A final settlement will be made at the end of the reporting period, not to exceed 100% of the indexed Medicaid costs for managed care enrollees." How does this differ under the prospective payment system from cost-based reimbursement?

RESPONSE: Please refer to the SECTION V: FQHC Prospective Payment System (PPS) response for all FQHC related questions.

4. Upper Payment Limit (UPL) Assurances

Under the terms of the waiver, Oklahoma is exempt fiom the UPL provisions of Section 1902(a)(30)(A), as implemented by 42 CFR 447.361 and 447.362. The State therefore is permitted to set capitation rates for qualifying MCOs' in excess of fee-for-service costs.

It has not proven necessary to exercise this waiver with respect to delivery payments. Instead, the State has been able to achieve simultaneously the objectives of preserving the financial health /of its MCOs while staying within program UPLs. And because the State initially made the payment only for births in excess of what had already been recognized in base capitation rates, it has never paid twice for the same service.

Exhibit IV below contains a summary of delivery payment amounts for each year, as well as the top of the rate range for the two Female rate categories (for informational purposes only). As it shows, the State has remained well under the UPL throughout the period in question.

Exhibit IV
Upper Payment Limit and Top Capitation Rate Ranges

	Top Capitation Rate		
Service Area	**Year III**	**Year IV**	**Year V**
Oklahoma City			
FM 15-20	$176.74	$127.02	$117.75
FM 21-44	$133.33	$104.58	$85.52
Delivery Payment	$2,330	$1,875	$2,490
Tulsa			
FM 15-20	$179.46	$145.13	$101.80
FM 21-44	$129.71	$110.41	$96.68
Delivery Payment	$2,330	$1,875	$2,490
Lawton			
FM 15-20	$163.29	$113.44	$101.80
FM 21-44	$129.48	$101.53	$60.94
Delivery Payment	$2,330	$1,875	$2,490

5. Qualifying Criteria and Method of Payment

The unanticipated increase in delivery rates was first observed in fall 1997 (near the end of Year III contract period) therefore, the OHCA is proposing a three-part amendment process. Part one includes delivery payments, for contract Year III, to the health plans, for uncompensated maternity expenses for deliveries that exceeded Year II delivery rates. Part two includes reimbursement for the inpatient component for contract Year IV with an additional incentive payment for deliveries performed by a medical resident. Part three

[1] To qualify, an MCO have be certified as a "Rural Partnership Plan", as defined in the waiver protocol. All of the MCOs hold this certification.

BUDGET NEUTRALITY PROJECTIONS - SFY-98 THROUGH SFY-04

This section provides a complete overview of budget neutrality calculations for the period of July 1, 1997 through June 30, 2004. As demonstrated in Exhibit I below Oklahoma's total program costs, prior to adjustments, for this period of time are estimated to be 73% of the fee-for-service equivalent (FFSE) with savings after adjustments totaling approximately $1,195,680,783 (26%), thereby demonstrating waiver savings versus FFS.

Attachment A provides a complete overview of expenditure estimates and budget neutrality assurance, by year, for SFY-98 through SFY-04. Attachment B provides the same information for each year broken down between the TANF and ABD managed care eligible groups. It is important to note that the ABD population was not enrolled in managed care until July 1, 1999, however, according to the Special Terms and Conditions the State must consider payments made during the entire waiver year (January 1, 1999 through December 31, 1999) when calculating budget neutrality.

Exhibit I
Total Expenditure and Savings Estimates

Budget Neutrality Assurances July 1, 1997 through June 30, 2004	
Expenditures	
Base Expenditures	$3,221,165,922
MCO Delivery Payments	$186,314,673
ABD Pharmacy Capitation Rate Adjustment	$3,666,461
Total Expenditures	**$3,411,147,056**
Fee-For-Service Equivalent	**$4,668,077,458**
Total Savings Before Adjustments	**($1,256,930,402)**
Medical Resident Physician Payments	$6,320,756
EPSDT Bonus Payments	$3,949,523
Resident PCP Delivery Payments	$3,649,379
ABD Choice Bridge Payments	$2,125,458
FQHC PPS Payments	$7,585,885
Enhanced Case Mgmt. SP/ABD (SC Plus)	$5,071,008
Graduate Medical Education Payments	$32.169.789
Total Savings After Adjustments	**($1,195,680,783)**
Federal Share	($836,976,548)
State Share	($358,704,235)

The OHCA, at the request of the PCP/CM, will consider quarterly bridge payments with an annual review and settlement process for providers that experience an adverse number of high utilizers during the course of the contract year. However, in addition to meeting the above requirements, encounter claims must be submitted within **45** days following the end of each State fiscal year quarter.

*Method **of** Payment*

For ***SoonerCare Choice*** members categorized as ABD, the OHCA will pay on an annual basis the difference between the provider's adjusted capitation revenue and the FFSE value of capitated services as defined by the benefit portion of the contract for their ***SoonerCare Choice*** ABD panel.

The OHCA shall make any adjustments in a lump sum payment within one hundred fifty (150) days after the end of the previous contract year. Beginning with the Year IV July 1,1999 – June 30,2000, the OHCA will:

1. Compare each provider's adjusted capitation revenue and the fee-for-service equivalent value of their to-date submitted clean encounter claims.
2. If the value of the encounter claims is less than the adjusted capitation revenue, no additional payment will be made.
3. If the value of the encounter claims exceeds the adjusted capitation revenue, the OHCA will make a payment of one hundred percent (100%) of the difference.

Recoupment will be made fiom any provider who correctly received a quarterly payment but whose annual adjusted capitation exceeded the value of the annual clean encounter claims for the contract year. Case management fees for ABD members will be exempt from the calculation.

1. Fee-for-Service Window

The State will reimburse providers for services delivered to individuals not yet enrolled in managed care using the existing Medicaid fee schedule. In setting capitation rate ranges or rates, the State's actuarial consultants first estimate the portion of total claims associated with prior quarter coverage and the "fee-for-service" window period (the time after eligibility is determined but before managed care enrollment takes effect) and remove these dollars from the capitation pool. By doing so, the State is able to assure that it remains below the upper payment limit for enrolled populations and does not capitate MCOs or PCCM physicians for services they will not be providing.

Corrective Action Plan

Problem:

The provisions of the Balanced Budget Act, which provide for extending the duration of State Health Reform Demonstrations, require the assessment the State's performance under the Special Terms and Conditions. There is special emphasis on performance under budget neutrality. ***An*** essential report for HCFA's assessment of budget neutrality is the form HCFA-64.9 waiver supplement. The State had began the process of extracting quarterly financial information in 1997, however, delays were encountered due to more pressing system issues and a lack of programmers. During the May 1999 site visit, the State agreed to provide HCFA with quarterly managed care expenditure information (by date-of-payment) dating back to the start of the waiver (January 1, 1996). Expenditure information is included in the annual budget neutrality reports, however, it is not broken down by quarters or included under the waiver section of the HCFA-64.9.

Corrective Action l

As of May 1999 the financial information extraction process was given priority and a system for generating/formatting managed care expenditure data, that meet HCFA-64.9 requirements, was developed. The process included assigning lead individuals from MMIS, finance, and the program design and evaluation unit in the extraction of this data. These individuals are responsible for creating methods for data extraction, validation, and submission of managed care expenditures for past-due and future quarterly reports.

Timeline:

A completion deadline was December 31, 1999.